DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445310	A. BUILDING _____ B. WING _____	03/09/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF COPPER BASIN	166 COPPER BASIN INDUSTRIAL PARK PO BOX 516 DUCKTOWN, TN 37326

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS During annual recertification survey and complaint investigation #25714, conducted on March 7 - 9, 2011, at Life Care Center of Copper Basin, no deficiencies were cited in relation to the complaint under 42 CFR PART 482.13, Requirements for Long Term care.	F 000	The filing of this Plan of Correction does not constitute an admission that the deficiencies alleged did in fact exist. This Plan of Correction is filed as evidence of Life Care Center of Copper Basin's desire to comply with the requirement and to continue to provide high quality resident care.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's	F 157	**F 157 483.10 (b) (11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)** **SS=D** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident #7 Licensed nurse caring for resident received one on one re-education that if meds were circled, reason was to be documented on back of MAR with documentation of MD notification. **Residents identified as having the potential to be affected by the same deficient practice. What corrective actions will be taken?** All residents have a potential to be affected. All current residents have been audited to ensure circled medications have reasons documented and MD notification. Audits conducted by DON, ADON, Unit Managers, SDC and were completed on March 24th 2011. **What measures will be put into place or systematic changes will be made to ensure that the deficient practice does not reoccur.**	4/12/2011

ORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that r safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days wing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ram participation.

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F 157	Continued From page 1 legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of the policy for Medication Administration, and interview, the facility failed to notify the physician of running out of ABHRP (Ativan) cream for one resident (#7) of twenty-four residents reviewed. The findings included: Resident #7 was admitted to the facility on March 23, 2010, and readmitted on June 4, 2010 with diagnoses including Muscle Weakness, Alzheimer's Disease, and Right Humeral Head Fracture. Medical record review of the Minimum Data Set dated January 24, 2011, revealed the resident had short and long term memory problems; was totally dependent with two plus person physical assistance for bed mobility, transfer, toilet use and bathing. Further review revealed the resident indicated pain by non-verbal sounds, facial expressions and protective body movements. Further review revealed pain or possible pain was observed one to two days of the last five days in the review process. Medical record review of the physician phone order dated October 14, 2010, revealed "...ABHRP (Ativan) cream apply 1 ml (milliliter) topically q (every) 6 hours...when cream arrives DC (discontinue) Ativan 1 mg (milligram) po (by mouth) 3 times a day..." Medical record review of the physician phone	F 157	Nursing staff were re-educated on documentation on back of MAR reason for circled medication and documentation of MD notification. Re-education was done by the staff development coordinator, DON, or ADON, and was completed by March 24th, 2011. **How the corrective action(s) will be monitored to ensure the deficient practice will not reoccur? What quality assurance program will be put into place.** The DON, ADON, and Unit Managers will audit daily to ensure that if a medication is circled there is reason documented on back of MAR and there is documentation of MD notification. The findings of the audits will be taken to the Performance Improvement Committee by the ADON for the next three months. The next meeting is set for April 12th.	

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F 157	Continued From page 2 order dated February 4, 2011, revealed "...(change) ABHRP cream to 3 x (times) daily 2) Ativan 2 mg po q day until ABHRP cream available..." Medical record review of the February 2011 Medication Administration Record (MAR) for ABHRP cream revealed on February 7, 2011 the ABHRP cream was not administered at 9:00 p.m.; on February 8, 2011, the ABHRP cream was not administered three times; and on February 9, 2011, at 3:00 a.m. the ABHRP cream was not administered as indicated by the circled initials. Further review of the back of the MAR revealed no documentation to explain why the ABHRP was not administered. Review of the facility policy for Medication Administration revealed "...Procedure...14. Circle initials on MAR if medication is not administered as ordered and record reason on MAR...21. If medication is ordered but not present: a. Check other resident drawers to see if it was placed in the wrong drawer...b. Call the pharmacy or supervisor to obtain the medication..." Interview, with the Regional Nurse in the dining room, on March 9, 2011, at 9:00 a.m., confirmed the ABHRP medication was not administered on February 7, 8 and 9, 2011, and confirmed there was no documentation the physician had been notified.	F 157		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.	F 176	F 176 483.10 (n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE SS=D What corrective action(s) will be	4/12/2011

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F 176	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility policy, observation and interview, the facility failed to assess a resident for self-administration of medications for one (#12) of twenty-four residents reviewed. The findings included: Medical record review revealed resident #12 was admitted to the facility on January 22, 2007 with diagnoses to include Chronic Airway Obstruction. Review of the Minimum Data Set (MDS) dated January 4, 2011, revealed the resident scored "15" on the Brief Interview for Mental Status (BIMS) indicating the highest score possible for repetition, temporal orientation, and recall. Medical record review of the Telephone Orders dated November 13, 2010, revealed an order to administer the nebulizer treatments three times a day. Medical record review of the Telephone Orders dated January 23, 2011, revealed an order to discontinue the nebulizer treatments "PRN" (as needed). Review of the facility's policy titled, "Self-Administration of Medications" revealed, "Each resident who desires to self-administer medications is permitted to do so if the facilities interdisciplinary team had determined the practice would be safe for the resident and other residents in the facility."	F 176	**accomplished for those residents found to have been affected by the deficient practice?** Resident #12 was assessed for self administration of medication per policy and was not deemed safe for self administering medication. Resident was informed that nurse would bring medication to resident when scheduled and prn. **Residents identified as having the potential to be affected by the same deficient practice. What corrective actions will be taken?** All residents have a potential to be affected. Residents currently self administering medication have been identified and assessed according to self administration policy. The monitoring of residents was done by the Unit Manager, DON, or ADON and was completed by March 24th 2011. **What measures will be put into place or systematic changes will be made to ensure that the deficient practice does not reoccur.** Nursing staff were re-educated on the policy for self administration of medications. The education was done by the staff development coordinator, DON, or ADON and was completed by March 24th 2011. **How the corrective action(s) will be monitored to ensure the deficient practice will not reoccur? What quality assurance program will be put into place?**	

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F 176	Continued From page 4 Observation on March 7, 2011, at 11:10 a.m., revealed resident #12 sitting on the side of the bed receiving supplement oxygen via nasal cannula. Continued observation revealed a hand-held nebulizer on the bedside table with an estimated ¼ solution remaining in the medication chamber. Continued observation and interview with resident #12 revealed, "They (the nurses) only give me 4 treatments a day...I split them up to make them last longer...I may need one right after they give me one...I get really short-winded sometimes...Just taking a little helps a lot.." Continued observation and interview revealed the resident had an ampule of the medication Albuterol in the bedside table to use "when I need it." Observation revealed resident #12 turned on the machine and self-administered a nebulization treatment after the interview. Review of the facility's 'Medication Self-Administration Review' dated March 7, 2011, revealed evaluation indicated, "This resident does not demonstrate competency in self-administration of medication..." Interview in the MDS office with the MDS Coordinator on March 7, 2011, at 2:20 p.m., verified the resident was not safe to self administer medications and the facility allowed the resident to self-administration the nebulizer treatments.	F 176	Residents will be monitored weekly to ensure that the self administration policy is being followed. The audits will be conducted by the DON, ADON and Unit Managers. The findings of the audits will be taken to the Performance Improvement Committee by the ADON for the next three months. The next PI meeting is set for April 12th.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to	F 280	**F 280 483.20 (d) (3) 483.10 (k) (2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP** **SS=D**	4/12/2011

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F 280	Continued From page 5 participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to update two resident's (#14, #7) care plans for safety devices to prevent falls of twenty-four sampled residents. The findings included: Resident #14 was admitted to the facility on July 13, 1999, with diagnoses including Alzheimer's Disease, Hypertension, and Osteoporosis. Medical record review revealed the resident had a history of falls. Review of documents provided by the facility, revealed the resident sustained falls without injury on these dates and the following interventions were to be put in place: June 4, 2010, Dycem (device to prevent sliding) to wheelchair, July 16, 2010, bed to be placed	F 280	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident # 14 care plan was updated to match current interventions in place for resident. Resident # 7 care plan was updated to match current interventions in place for resident. **Residents identified as having the potential to be affected by the same deficient practice. What corrective actions will be taken.** All residents having safety devices in place have a potential to be affected. All residents with safety devices were audited to ensure that care plan matches current interventions ordered. The audits were done by the DON, ADON, SDC, Unit Managers. Audits were completed by March 24th 2011. **What measures will be put into place or systematic changes will be made to ensure that the deficient practice does not reoccur.** Nursing staff were re-educated on updating careplans when safety devices are ordered. The re-education was given by the SDC, DON, or ADON and was completed March 24th 2011. **How the corrective action(s) will be monitored to ensure the deficient practice will not reoccur?** The Unit Managers, DON, ADON will audit charts for careplan updates on any new orders for safety devices. New orders will be checked	

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F 280	Continued From page 6 against the wall with mat at bedside, and August 2, 2010, pressure alarms to be applied to bed and chair. Medical record review of the resident's Care Plan revealed no interventions of dycem, bed against the wall, or pressure alarm. Interview with the Unit Coordinator in the Unit Coordinator's office on March 8, 2010, at 10:30 a.m., confirmed the resident's Care Plan had not been updated to reflect the interventions. Resident #7 was admitted to the facility on March 23, 2010, and readmitted on June 4, 2010, with diagnoses including Muscle Weakness, Alzheimer's Disease, and Right Humeral Head Fracture. Medical record review of the Minimum Data Set dated January 24, 2011, revealed the resident had short and long term memory problems; was totally dependent with two plus person physical assistance for bed mobility, transfer, toilet use and bathing. Further review revealed the resident indicated pain by non-verbal sounds, facial expressions and protective body movements. Further review revealed pain or possible pain was observed one to two days of the last five days in the review process. Further review revealed the resident had ahistory of a fall after admission with no injury. Medical record review of the Fall Risk Assessments dated July 3, 2010 through January 24, 2011, revealed the resident was at high risk	F 280	daily. The findings of the audits will be taken to the Performance Improvement Committee by the ADON for the next 3 months, beginning with the next meeting which is set for April 12th, 2011.	

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F 280	Continued From page 7 for falls. Medical record review of a physician phone order dated August 2, 2010, revealed "...Pull tab alarm while in bed-check q (every) shift for proper functioning and placement...mat beside bed for safety..." Medical record review of a physician phone order dated August 10, 2010, revealed "...Mats to both sides of bed..." Medical record review of the nursing note dated August 12, 2010, revealed "...Late entry for 8/11/10. Res (Resident) noted to climb OOB (out of bed) to bed side mat. Small abrasion area noted to (R) (right) forearm...no other injuries noted..." Medical record review of the nursing note dated October 17, 2010, revealed "...Res at 1:15pm was witnessed to stand up for (sic)sitting on side of bed and fall sideways unto back and back of head hitting head on floor. cna (Certified Nurse Aide) was in room with other resident and witnessed and was unable to get to res before...fell....mat was in front of bed but not past foot of bed..." Medical record review of the nursing note dated October 23, 2010, revealed "...Res was on mat with head off (mat)...has reddened area left eyebrow. Neuros per protocol. Res spouse called, MD notified and told res and spouse wishes, per spouse request res is not going to hospital..." Review of facility documentation dated August 11, 2010; October 17, 2010; October 23, 2010; and	F 280		

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F 280	Continued From page 8 January 10, 2011, revealed the resident had fallen out of the bed and there was no documentation the bed alarm was sounding. Further review of the facility documentation dated August 11, 2010, revealed the additional intervention was to place the resident in a recliner with a pull tab alarm. Further review of the facility documentation dated October 17, 2010, revealed the additional interventions were to do environmental check of alarms and furniture placement. Further review of the facility documentation dated October 23, 2010, revealed the additional intervention was low bed in place, mat on wall, bed turned to wall, rearrange mats placing 3 mats vertically to bed. Further review of the facility documentation dated January 10 2011, revealed the additional intervention was to ensure the bedside table was across the room against the wall. Review of the care plan dated April 8, 2010, revealed Hi-lo bed, mats bilaterally to floor beside bed. Further review revealed the tab alarm to the bed was not added after the order was obtained on August 2, 2010. Continued review revealed the alarm to bed was added on October 23, 2010. Observation on March 7, 2011, at 1:52 p.m., revealed the resident in a Broda chair with thigh straps, in constant motion, hit her left forehand on rail and got a skin tear. Continued observation revealed the resident was taken to the resident's room and four mats were on the floor by the bed; the bed was against the wall with a mat between the wall and the bed; the bed was in a low position and a tab alarm was attached to the bed. Interview with the Unit Coordinator in the Unit Coordinator's office on March 8, 2010, at 12:20	F 280		

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F 280	Continued From page 9 p.m., confirmed the resident's Care Plan had not been updated to reflect the interventions.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to discontinue a medication as ordered by the physician for one resident (#1) of twenty-four reviewed. The findings included: Resident #1 was re-admitted to the facility on March 4, 2011, with diagnoses including Urinary Tract Infection, Dysphagia, Decubitus Ulcer Dementia, and Alzheimer's. Medical record review of the Medication Reconciliation form from the hospital dated March 4, 2011, revealed the resident was admitted to the hospital on February 27, 2011, with orders to continue Amlodipine (blood pressure medication) 5 milligrams (mg) daily and the medication was discontinued at discharge. Medical record review of the facility's Physician's Admission Orders dated March 4, 2011, revealed no orders for Amlodipine 5 mg. Medical record review of the MAR (Medication Administration Record) dated March, 2011, revealed Amlodipine 5 mg had been administered daily on March 5, 6, 7, and 8, 2011.	F 281	**F 281 483.20 (k) (3) (i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS** **SS=D** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident # 1 MD was notified and Amlodipine was D/C'd on March 8th 2011. **Residents identified as having the potential to be affected by the same deficient practice. What corrective actions will be taken?** All residents being admitted or re-admitted to the facility have a potential to be affected. The DON, ADON, Unit Managers or SDC audited all residents being admitted after the last Medication Recapulation completed February 28th 2011 to ensure that all medication reconciliation forms (home med form) were completed upon admission to the facility. Audits were completed March 24th, 2011. **What measures will be put into place or systematic changes will be made to ensure that the deficient practice does not reoccur.** Nursing staff were re-educated on following policy for medication reconciliation (home	4/12/2011

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F 281	Continued From page 10 Medical record review and interview with LPN (licensed practical nurse) #3 on March 8, 2011, at 10:10 a.m., at the nursing station, confirmed the resident had received the Amlodipine 5 mg without a physician's order.	F 281	medication form) with new admissions and re-admits. The education was done by the SDC, DON, or ADON and was completed March 24th 2011. **How the corrective action(s) will be monitored to ensure the deficient practice will not reoccur?** The DON, ADON, and Unit Managers will audit all new admits and re-admits to ensure medication reconciliation has been done. Findings of the audits will be taken to the Performance Improvement Committee by the ADON for the next 3 months beginning with the meeting set for April 12th 2011.	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, facility policy and interview, the facility failed to complete a bladder assessment, failed to provide clinical justification for an indwelling catheter, and failed to offer treatment to restore as much bladder function as possible for one resident (#11) of twenty-four residents reviewed. The findings included: Medical record review revealed resident was admitted to the facility on January 27, 2011 with diagnoses to include Rehabilitation and Urinary Tract Infection.	F 315	**F 315 483.25 (d) NO CATHETER, PREVENT UTI, RESTORE BLADDER SS=D** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident # 11 had catheter justification form, bladder assessment, and urinary incontinence questionnaire completed. MD was notified and diagnosis of Neurogenic bladder was added on March 22nd 2011 **Residents identified as having the potential to be affected by the same deficient practice. What corrective actions will be taken?**	4/12/2011

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F 315	Continued From page 11 Medical record review of the admission nursing notes revealed the resident was admitted with an indwelling catheter. Review of the Minimum Data Set dated February 3, 2011, revealed the resident scored "15" on the Brief Interview for Mental Status (BIMS) indicating the highest score possible for repetition, temporal orientation, and recall. Review of the facility's "Urinary Incontinence Questionnaire" and the "Assessment for Bowel and Bladder Training" revealed both assessment tools had not been completed. Observation on March 7, 2011, at 10:15 a.m., revealed resident #11 lying supine in bed and a Foley catheter drainage collection bag containing yellow urine was attached to the bed rail. Observation and interview with resident #11 on March 8, 2011, at 3:30 p.m., revealed the resident in bed and easily engaged in conversation Continued interview revealed the resident had the catheter "for quite some time" and "wish I did not have to have it." Continued interview revealed the facility had not offered any treatment to restore bladder function. Review of the facility policy titled,"Guidelines for Completing the Urinary Assessments and Indwelling Catheter Assessment and Other Forms revealed...4. If the resident has an indwelling cather on admission the charge nurse will complete the Indwelling Catheter form." Review of the medical record revealed no documentation of a completed "Indwelling	F 315	Residents having an indwelling catheter. All current residents with indwelling catheters were audited for completion of catheter justification sheet, bowel & bladder assessment, and incontinence questionnaire. The monitoring was done by the DON, ADON, Unit Managers and SDC and was completed by March 24th 2011. **What measures will be put into place or systematic changes will be made to ensure that the deficient practice does not reoccur.** Nursing staff were re –educated on completing the catheter justification, bowel and bladder assessment form and incontinence questionnaire form on any resident admitted with a catheter or any current resident with a newly acquired catheter. The education was done by the SDC, DON, or ADON and was completed March 24th, 2011. **How the corrective action(s) will be monitored to ensure the deficient practice will not reoccur?** All current residents with catheters were audited to ensure assessment of bowel and bladder, catheter justification, and incontinence questionnaire were completed. All residents being admitted with catheters will be audited by the DON, ADON, or Unit Mangers to ensure catheter justification form, incontinence assessment and bowel and bladder assessment is completed. The findings of the audits will be taken to the Performance Improvement Committee by the ADON for the next 3 months beginning with the next meeting	

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F 315	Continued From page 12 Catheter form." Interview with the Unit Manager (UM) of the North Wing on March 8, 2011, at 3:25 p.m., in the office of the UM, confirmed the facility did not complete the bladder assessment, questionnaire, or indwelling catheter form; did not offer treatment to restore bladder function, and did not have medical justification for the indwelling catheter.	F 315	set for April 12th, 2011.	
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility documents, observation and interview, the facility failed to ensure safety devices were in place to prevents falls for three residents (#14, #16, & #7) of twenty-four sampled residents. The findings included: Resident #14 was admitted to the facility on July 13, 1999, with diagnoses including Alzheimer's Disease, Hypertension, and Osteoporosis. Medical record review revealed the resident had a history of falls. Review of documents provided by the facility, revealed the resident experienced the following falls without injury on these dates. The	F 323	F 323 483.25 (h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES SS=E **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident #14, On March 8th interventions for resident were put into place and care plans were updated to match current interventions ordered. Resident # 16 On March 9th interventions for resident were put into place and care plans were updated to match current intervention orders. Resident # 7 On March 8th interventions for resident were put into place and care plans were updated to match current interventions. Education with nurse to ensure documentation that interventions were in place at time of fall was begun and completed by March 24th 2011. **Residents identified as having the potential to be affected by the same deficient practice. What corrective actions will be taken?**	4/12/2011

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F 323	Continued From page 13 interventions put in place following the falls were as noted: June 4, 2010, Dycem (device to prevent sliding) to wheelchair, July 16, 2010, bed to be placed against the wall with mat at bedside, and August 2, 2010, pressure alarms to be applied to bed and chair. Medical record review and review of documents provided by the facility, revealed the resident sustained falls from the wheelchair on August 11, and 16, 2010, with no documentation the alarm was in place and sounding, and no documentation the dycem was in place. Medical record review and review of facility documents, revealed the resident sustained a fall without injury from the bed on October 27, 2010, with no documentation the alarm was in place and sounding and no documentation the mat was at bedside. Observation on March 8, 2010, at 8:20 a.m. revealed the resident lying in a low bed against the wall, with a fall mat in place. Interview with the Unit Coordinator in the Unit Coordinator's office on March 8, 2010, at 10:30 a.m., confirmed the resident's Care Plan had not been updated to reflect the interventions and confirmed no documentation the safety devices were in place at the time of the resident's falls. Resident #16 was admitted to the facility on May 31, 2007, with diagnoses including Alzheimer's Disease, Muscle Weakness, Anxiety State, and Dementia with Behavior Disturbance. Medical record review of the Minimum Data Set dated December 17, 2010, revealed the resident had short term memory problems, no long term	F 323	All residents at risk for falls have a potential to be affected. All current residents who have interventions in place for falls are being monitored every shift to ensure safety devices are in place and functioning properly by the hall nurse. Audits have been on going since survey March 9th 2011. **What measures will be put into place or systematic changes will be made to ensure that the deficient practice does not reoccur.** Nursing staff were re-educated on ensuring that safety devices are being utilized and/or functioning properly every shift and documenting what safety devices were being utilized and functionality at the time of a fall. The re-education was done by the SDC, DON, or ADON and was completed by March 24th, 2011. **How the corrective action(s) will be monitored to ensure the deficient practice will not reoccur?** In addition to the hall nurses monitoring safety devices every shift, the Unit Mangers, DON, SDC, and ADON are monitoring safety devices once a week to ensure they are being utilized and are functioning properly. The findings of the audits will be taken to the Performance Improvement Committee by the ADON for the next 3 months. The next PI meeting is set for April 12th 2011.	

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F 323	Continued From page 14 memory problems, and modified independence in cognitive skills; required limited assistance with transfers and ambulation; was not steady and required human assistance for moving from seated to standing, walking, turning around, and surface to surface transfers; had two falls, without injury, since the last assessment. Medical record review of the resident's care plan updated November 18, 2010, revealed, "...Place pull tab alarm to bed & chair to alert staff of unassisted transfers..." Medical record review of a nursing note dated December 20, 2010, at 10:36 p.m., revealed, "Found laying on back on floor next to walker next to bed. Bed alarm on. Confuse (confused) Neuro check completed. Small bump on back of head. No redness noted. Denies pain/headache. Ice pack applied to back of head for 15 min Move all extremities as before..." Medical record review of the care plan updated December 21, 2010, revealed the resident was placed on a prompted toileting plan. Medical record review of a nursing note dated December 26, 2010, at 11:40 p.m., revealed, "Found sitting bathroom floor holding back of...head. Laceration 1 cm (centimeter) noted. Alert/confuse (confused). Respond appropriately to question. Bil (bilateral) Pupil react equally/Brisk 2 mm (millimeter) size. Denies headache. Move all extremities as before. Assisted back to bed ambulate with walker. Bed alarm applied...requested to be sent to ER (emergency room) for Evaluation..." Medical record review of the nursing notes revealed the resident returned from the emergency room on December 27, 2010, at 2:15 a.m., with new	F 323		

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F 323	Continued From page 15 orders to increase blood pressure medication dosages. Observation of the resident on March 9, 2011, from 11:32 a.m., to 11:35 a.m., and interview with the Director of Nursing (DON), in the resident's room, confirmed the resident was sitting in a wheelchair with no tab or personal alarm attached, and the DON, after finding the alarm under a pillow, attached the alarm to the resident. Observation of the resident and interview with LPN (Licensed Practical Nurse) #2 on March 9, 2011, at 11:36 a.m., and 11:50 a.m., outside the resident's room, confirmed the resident had a tab alarm in the wheelchair at all times and a pressure alarm in the bed. Continued interview revealed the LPN did not know when the pressure alarm to the bed had been implemented. Observation of the resident on March 9, 2011, at 11:55 a.m., in the resident's room, revealed the resident was sitting on the side of the bed, and when lifted the bottom, the pressure alarm sounded, and the resident quickly sat back down. Interview with the resident, at that time, confirmed the resident had transferred, unassisted, to the bed and the resident stated the tab alarm, "was already off." Continued interview confirmed the pressure alarm on the bed alarmed whenever the resident moved his/her bottom and the resident had to sit down to quiet the alarm. Interview with the Unit Coordinator (UC) on March 9, 2011, at 11:47 a.m., in the UC's office, confirmed the resident's care plan indicated the resident was to have a tab alarm in the bed and chair, and the UC was unaware the resident had a pressure alarm to the bed.	F 323		

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F 323	Continued From page 16 Interview with the DON on March 9, 2011, in the resident's room, and medical record review and interview with the DON and LPN #2, at 12:00 p.m., at the nursing station, confirmed a physician's order dated November 18, 2010, discontinued the pressure alarm to the bed, added a tab alarm to the wheelchair and bed, and the care plan reflected those orders. Continued interview confirmed the resident did not have an alarm attached while sitting in the wheelchair at 11:32 a.m., and the staff was aware the tab alarm to the wheelchair was ineffective because the resident had a history of removing the tab alarm and transferring unassisted to the bed. Continued interview confirmed the resident was at risk for falls and the resident had not been assessed for the use of an alternative pressure alarm to the wheelchair and bed. Resident #7 was admitted to the facility on March 23, 2010, and readmitted on June 4, 2010, with diagnoses including Muscle Weakness, Alzheimer's Disease, and Right Humeral Head Fracture. Medical record review of the Minimum Data Set dated January 24, 2011, revealed the resident had short and long term memory problems, was totally dependent with two plus person physical assistance for bed mobility, transfer, toilet use and bathing. Further review revealed the resident indicated pain by non-verbal sounds, facial expressions and protective body movements. Further review revealed pain or possible pain was observed one to two days of the last five days in the review process. Further review revealed the resident had a history of a fall since admission.	F 323		

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F 323	Continued From page 17 Medical record review of the Fall Risk Assessments dated July 3, 2010 through January 24, 2011, revealed the resident was at high risk for falls. Medical record review of a physician phone order dated August 2, 2010, revealed "...Pull tab alarm while in bed-check q (every) shift for proper functioning and placement...mat beside bed for safety..." Medical record review of a physician phone order dated August 10, 2010, revealed "...Mats to both sides of bed..." Medical record review of the nursing note dated August 12, 2010, revealed "...Late entry for 8/11/10. Res (Resident) noted to climb OOB (out of bed) to bed side mat. Small abrasion area noted to (R) (right) forearm...no other injuries noted..." Medical record review of the nursing note dated October 17, 2010, revealed "...Res at 1:15pm was witnessed to stand up for (sic)sitting on side of bed and fall sideways unto back and back of head hitting head on floor. cna (Certified Nurse Aide) was in room with other resident and witnessed and was unable to get to res before...fell....mat was in front of bed but not past foot of bed..." Medical record review of the nursing note dated October 23, 2010, revealed "...Res was on mat with head off (mat)...has reddened area left eyebrow. Neuros per protocol. Res spouse called, MD notified and told res and spouse wishes, per spouse request res is not going to	F 323		

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F 323	Continued From page 18 hospital..." Review of facility documentation dated August 11, 2010; October 17, 2010; October 23, 2010, and January 10, 2011, revealed the resident had fallen out of the bed and there was no documentation the bed alarm was sounding. Further review of the facility documentation dated August 11, 2010, revealed the additional intervention was to place the resident in a recliner with a pull tab alarm. Further review of the facility documentation dated October 17, 2010, revealed the additional interventions were to do environmental check of alarms and furniture placement. Further review of the facility documentation dated October 23, 2010, revealed the additional intervention was low bed in place, mat on wall, bed turned to wall, rearrange mats placing 3 mats vertically to bed. Further review of the facility documentation dated January 10, 2011, revealed the additional intervention was to ensure the bedside table was across the room against the wall. Review of the care plan dated April 8, 2010, revealed Hi-lo bed, mats bilaterally to floor beside bed. Further review revealed the tab alarm to the bed was not added after the order was obtained on August 2, 2010. Continued review revealed the alarm to bed was added on October 23, 2010. Observation on March 7, 2011, at 1:52 p.m. revealed the resident in a Broda chair with thigh straps, in constant motion, hit her left fore hand on rail and got a skin tear. Continued observation revealed the resident was taken to the resident's room and four mats were on the floor by the bed; the bed was against the wall with a mat between the wall and the bed; the bed was in a low	F 323		

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F 323	Continued From page 19 position and a tab alarm was attached to the bed. Interview with the Unit Coordinator in the Unit Coordinator's office on March 8, 2010, at 12:20 p.m., confirmed there was no documentation the safety devices were in place at the time of the resident's falls.	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to accommodate choices in individual food preferences for one resident (#2) of twenty-four reviewed. The findings included: Resident #2 was re-admitted to the facility on December 27, 2010, with diagnoses including Sepsis, UTI (Urinary Tract Infection), Alzheimer's Dementia, and Parkinson's Disease. Medical record review of the Minimum Data Set dated January 3, 2011, revealed the resident had	F 325	**F 325 483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE SS=D** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident #2 received extra portion of gravy biscuit and special request was placed using the dietary communication form on March 8th. **Residents identified as having the potential to be affected by the same deficient practice. What corrective actions will be taken?** All residents have a potential to be affected. Residents will be asked if they have any special requests from dietary that are not being met. The special request audits will be done by the dietary department and will be completed by March 24th 2011. **What measures will be put into place or systematic changes will be made to ensure that the deficient practice does not reoccur.** Nursing staff were re-educated to notify the	4/12/2011

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F 325	Continued From page 20 long and short term memory problems, moderately impaired cognition, was totally dependent on staff for all activities of daily living, and was on a mechanically altered diet. Observation and interview with the resident on March 8, 2011, at 8:30 a.m., in the resident's room revealed the resident stated breakfast was a biscuit and gravy, which the resident ate "all" and the resident wanted more biscuit and gravy, but was told there was no more. Interview with CNA (Certified Nursing Assistant who fed the resident) #1 on March 8, 2011, at 8:35 a.m., at the nursing station, confirmed the resident's favorite meal was biscuits and gravy and always requested a second serving. Interview with the Dietary Manager and Assistant Dietary Manager on March 8, 2011, at 8:40 a.m., in the Dietary Manager's office, confirmed staff had not requested a second serving of biscuit and gravy for the resident, the resident had not received a second serving, and the dietary department was unaware the resident ever requested or received second servings of biscuits and gravy in the past. Observation and interview with the resident on March 8, 2011, at 9:05 a.m., in the resident's room, confirmed the resident had received another serving of biscuit and gravy, had eaten approximately half of it and was now satisfied. Interview with CNA #2 on March 8, 2011, at 9:25 a.m., at the nursing station, confirmed the resident had eaten approximately half of the second serving of biscuit and gravy. Further interview revealed, "(resident) likes to holler	F 325	kitchen anytime a resident is making a special dietary request. The re-education was done by the SDC, DON, or ADON and was completed March 24th 2011. **How the corrective action(s) will be monitored to ensure the deficient practice will not reoccur?** Dietary staff member will meet with resident council monthly for the next 3 months to ensure that all dietary special requests are being followed up on. The findings of the meetings will be taken to the Performance Improvement Committee by the Dietary Manager for the next three months beginning with the next meeting set for April 12th 2011.	

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445310	A. BUILDING _____ B. WING _____	03/09/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF COPPER BASIN	165 COPPER BASIN INDUSTRIAL PARK PO BOX 518 DUCKTOWN, TN 37326

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 21 biscuit and gravy so the resident can get more and say we didn't give it to them." Interview with the Dietary Manager and the Assistant Dietary Manager on March 8, 2011, at 8:40 a.m., and on March 9, 2011, at 9:10 a.m., in the Dietary Manager's office, confirmed the dietary department always provided additional servings of food when staff requested it for residents. Further interview confirmed the resident was considered a nutritional risk and the dietary department needed to be informed of the resident's special dietary requests to ensure the resident received optimum nutrition to meet needs. Further interview confirmed staff had not communicated the resident's requests to the dietary department and the resident's dietary preferences had not been honored.	F 325		
F 364 SS=F	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to serve food at a palatable temperature. The findings included: Observation of the residents mid-day meal trayline service on March 9, 2011, at 11:13 a.m., revealed the following food temperatures obtained by the Assistant Dietary Manager:	F 364	**F 364 483.35(d)(1)-(2) NUTRIVE VALUE/APPEAR, PALITABLE / PREFER TEMP** **SS=F** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** On March 9th starting with the evening meal trays, residents not in dining room trays were delivered to rooms immediately and not left sitting in the dining room for any period of time. Process has been ongoing since that time. **Residents identified as having the potential**	4/12/2011

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F 364	Continued From page 22 1.) Meatloaf and turnip greens were 164 degrees Fahrenheit (F). 2.) Mashed potatoes was 170 degrees F 3.) Pureed meatloaf and pureed turnip greens were 168 degrees F. 4.) Milk was 34 degrees F. A test tray was requested for the cart in process of being filled. Observation revealed the cart contained fifteen trays with the test tray included and was completed at 11:20 a.m.; the cart left the department at 11:21 a.m., and was delivered to the floor at 11:22 a.m. Further observation revealed the first tray was removed and delivered at 11:22 a.m.; last tray delivered was 12:01 p.m., and the last resident served began eating at 12:07 p.m. Observation revealed one resident tray and the test tray remained on the tray cart that arrived to the floor at 11:22 a.m. Observation revealed a tray cart, containing five trays for residents who usually ate in the dining room but decided not to, was delivered to the floor at approximately 11:53 a.m. Observation revealed the nursing staff delivered the five trays from the cart that arrived to the floor at 11:53 a.m. through 12:07 p.m. and left the one resident tray on the cart that arrived at 11:22 a.m. Food temperatures were obtained by the Assistant Dietary Manager from the test tray at 12:07 p.m. with the following results: 1.) Meatloaf was 106 degrees F. 2.) Turnip greens was 110 degrees F. 3.) Mashed potatoes was 112 degrees F. 4.) Pureed meatloaf and pureed turnip greens were 112 degrees F. 5.) Milk was 54 degrees F.	F 364	**to be affected by the same deficient practice. What corrective actions will be taken?** All residents have a potential to be affected, and the facility will ensure the meals are delivered at the proper temperatures. **What measures will be put into place or systematic changes will be made to ensure that the deficient practice does not reoccur.** All available staff will assist with the meals delivered to the residents. All residents will be re-evaluated for appropriate dining locations. These efforts will ensure that this does not reoccur. **How the corrective action(s) will be monitored to ensure the deficient practice will not reoccur?** The CDM and or the Assistant CDM will audit 10% of trays weekly to ensure the resident's meals are at the proper temperatures when they receive them. These findings will be brought to the Performance Improvement Committee monthly for six months to ensure compliance. The next meeting is set for April 12th 2011.	

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F 364	Continued From page 23 Interview, with the Assistant Dietary Manager on March 9, 2011, at 12:09 p.m., outside the 100 hall Day Room confirmed the test tray food temperatures had decreased significantly from the tray line temperatures. Further interview revealed the food "was not hot enough and the milk (temperature) was to high." Interview of five of five residents in the group meeting, on March 8, 2011, at 2:30 p.m., revealed the "food was barely warm."	F 364		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain sanitary equipment in the dietary department. The findings included: Observation on March 7, 2011, at 11:56 a.m., with the Director of the Dietary Department revealed the following: 1. Four individual storage bins containing cornmeal, flour and sugar had dried red and black	F 371	**F 371 483.35 (i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY SS= F** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The individual storage bins and floor mixer were immediately cleaned. The clean rack of dishes that were placed on the floor were re-washed and placed off floor. The clean dish racks that were ejected by the dirty dish rack were re-washed. **Residents identified as having the potential to be affected by the same deficient practice. What corrective actions will be taken?** All resident have a potential to be affected. The individual storage bins and floor mixer were immediately cleaned. The clean rack of dishes that were placed on the floor were re-washed and placed off floor. The clean dish	4/12/2011

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F 371	Continued From page 24 colored debris on the lids and exterior surface of the bins. 2. The floor mixer underside of the beater arm, the back of the base and the exterior of the base had an accumulation of white and tan colored splattered debris. Observation of the dishroom operation in process on March 8, 2011, at 1:50 p.m., with the Director of the Dietary Department and Assistant Dietary Manager revealed the following: 1.) Two dish racks stored in contact with the floor. 2.) The dietary staff member working the dirty side of the dish machine pushed a rack filled with dirty dishes into the machine. Further observation revealed the dirty dish rack came in contact with the rack of clean dishes inside the machine. Continued observation revealed the clean rack of dishes was ejected from the machine by the dirty rack of dishes. Interview with the Director of the Dietary Department on March 7, 2011, at 11:56 a.m., confirmed the four storage bins had dried debris on the lids and exterior surface. Further interview confirmed the floor mixer had an accumulation of dried white and tan colored splattered debris on the underside of the beater arm, the back of the base and the exterior surface. Further interview revealed the floor mixer had not been used on March 7, 2011. Interview with the Director of the Dietary Department and the Assistant Dietary Manager on March 8, 2011, at 1:50 p.m., confirmed two dish racks were in contact with the floor. Continued interview confirmed the dirty dish rack was pushed into the clean rack of dishes inside	F 371	racks that were ejected by the dirty dish rack were re-washed. **What measures will be put into place or systematic changes will be made to ensure that the deficient practice does not reoccur.** Kitchen staff were re-educated on ensuring that storage bins and mixer are cleaned and the process to ensure clean dishes do not touch dirty surfaces after they have been washed. The re-education was done by the Dietary Manager and was completed by March 24th 2011. **How the corrective action(s) will be monitored to ensure the deficient practice will not reoccur? What Quality Assurance Program will be put into place?** The cook is auditing daily to ensure food storage bins are clean and floor mixer is kept clean and that clean dishes are not touched by dirty surfaces. The findings of the audits will be taken to the Performance Improvement Committee by the Dietary Manager for the next three months beginning with the meeting set for April 12th 2011.	

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F 371	Continued From page 25 the machine in order to eject the clean rack of dishes from the machine.	F 371		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	**F 441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS** **SS= E** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident # 3 One on one re-education on infection control practices with tracheostomy care was done with all licensed nurses giving direct care to resident was begun on March 8th 2011 and completed on March 24th 2011. Re-education for all nursing staff on infection control practices with tracheotomy care was begun on March 8th 2011 and completed on March 24th 2011. Resident #2 One on one re-education on infection control practices during dressing change was done with the wound care nurse on March 8th 2011. Licensed nursing staff re-education on infection control practices during dressing change was begun on March 8th 2011 and was completed by March 24th 2011. **Residents identified as having the potential to be affected by the same deficient practice. What corrective actions will be taken?** All residents have a potential to be affected. The infection control nurse and DON reviewed all residents with active infections to ensure residents were receiving appropriate isolation precautions. The review was completed by	4/12/2011

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F 441	Continued From page 26 This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, policy review, and interview, the facility failed to change gloves properly during tracheostomy care for one (#3); failed to wash/cleanse the hands properly during care of a pressure ulcer for one (#2), and failed to isolate two residents with multiple drug resistant organisms (#1, #11) of twenty-four residents reviewed. The findings included: Resident #3 was admitted to the facility on October 5, 2004, with diagnosis including Bronchitis and Brain Injury post Motor Vehicle Accident. Medical record review revealed resident #3 was completely dependent on the staff to meet all needs. Observation on March 7, 2011, at 10:50 a.m., revealed resident had a Tracheostomy (a surgically created opening creating a direct airway to the trachea/windpipe) and was receiving supplemental oxygen via trach collar. Continued observation revealed Licensed Practical Nurse (LPN #1) was in the process of performing tracheostomy. Continued observation revealed LPN #1 (with gloved hands) used a gauze sponge and removed yellow secretions from around the stoma (the opening) then disposed of the gauze in the garbage. Continued observation revealed LPN #1 without removing the gloves, picked up the saline bottle and put it in the bedside drawer	F 441	March 9th 2011. **What measures will be put into place or systematic changes will be made to ensure that the deficient practice does not reoccur.** Nursing staff was re–educated on appropriate isolation. Licensed Nurses were re-educated on infection control techniques for tracheostomy care and wound care. The education was done by the infection control nurse, SDC, DON, or ADON and was completed by March 24th 2011. **How the corrective action(s) will be monitored to ensure the deficient practice will not reoccur?** Infection control technique audits for wound care and tracheostomy care are being done three times a week by the infection control nurse. Isolation precautions audits are being done 3 times a week by the infection control nurse to ensure residents are in appropriate isolation. Findings of the audits will be taken to the Performance Improvement Committee by the ADON for the next three months beginning with the next meeting set for April 12th 2011.	

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F 441	Continued From page 27 and closed the drawer with the gloved hands. Continued observation revealed LPN #1 removed the gloves and cleansed the hands. Continued observation revealed LPN #1 gathered equipment and prepared to change the inner cannula trach tube. (The outer cannula remains in place to keep the airway open and the inner cannula is replaced periodically). LPN #1 removed the inner cannula containing yellow secretions and placed it on a paper towel and without removing the gloves, placed the new inner cannula into the outer cannula of the Trachestomy. Interview with LPN #1 in the resident's room on March 7, 2011, at 11:08 a.m., verified the contaminated gloves were not removed prior to handling the normal saline bottle and drawer handle and verified the contaminated gloves were not removed prior to inserting a new inner cannula. Interview with the Director of Nursing (DON) in the DON's office on March 8, 2011, at 1:18 p.m., confirmed the facility failed to follow infection prevention protocol to separate dirty from clean. Resident #11 was admitted to the facility on January 27, 2011, with diagnoses including Rehabilitation and Urinary Tract Infection. Medical record review revealed resident #11 was admitted with an order for Septra DS (antibiotic) one tablet for 5 days to complete the treatment for a UTI (Urinary Tract Infection). Medical record review of the admission nursing notes revealed the resident was admitted with an indwelling catheter.	F 441		

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F 441	Continued From page 28 Observation on March 7, 2011, at 10:15 a.m., revealed resident #11 lying supine in bed and a Foley catheter drainage collection bag containing yellow urine attached to the bed rail. Medical record review of the admission orders dated January 27, 2011, revealed an order for a monthly Urinalysis (UA) with Culture and Sensitivity (C/S). Medical record review revealed a telephone order dated February 6, 2011, to obtain a Urinalysis with Culture and Sensitivity. Medical record review revealed no results of the UA and C/S for February. Medical record review of the urinalysis with culture and sensitivity obtained March 6, 2011, revealed the resident had a urinary tract infection (UTI) with greater than 100,000 Escherichia coli (E. coli) that was resistant to all antibiotics except Nitrofurantoin. Review of the facility's policy Isolation for Communicable Diseases revised May 21, 2004, revealed "Contact Precautions...It is the intent of this facility to use contact precautions for residents known or suspected to have serious illnesses easily transmitted by direct resident contact or by contact with items in the residents' environment...Examples of Infections When Contact Precautions May Be Considered: Multi-resistant organisms (e.g. VRE [Vancomycin Resistant Enterococcus])..." Interview with the Infection Control Practitioner on March 9, 2011, at 10:40 a.m., in the Unit	F 441		

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F 441	Continued From page 29 Coordinator's office, and at 11:30 a.m., in the Social Services offices, confirmed residents with multi-drug resistant E. Coli UTIs were to be placed in contact isolation. Further interview confirmed the resident had a multi-drug resistant E. Coli UTI infection and had not been placed in contact isolation as indicated by the facility's policy. Resident #1 was re-admitted to the facility on March 4, 2011, with diagnoses including Urinary Tract Infection, Dementia, and Alzheimer's. Medical record review of the Minimum Data Set dated February 26, 2011, revealed the resident had long and short term memory problems, severely impaired cognition, totally dependent on staff for all activities of daily living and was always incontinent of bladder. Medical record review of a urinalysis and culture and sensitivity obtained February 28, 2011, revealed the resident had a urinary tract infection (UTI) with greater than 100,000 Escherichia coli (E. Coli) that was resistant to all antibiotics except Nitrofurantoin. Review of the facility's policy Isolation for Communicable Diseases revised May 21, 2004, revealed "Contact Precautions...It is the intent of this facility to use contact precautions for residents known or suspected to have serious illnesses easily transmitted by direct resident contact or by contact with items in the residents' environment...Examples of Infections When Contact Precautions May Be Considered: Multi-resistant organisms (e.g. VRE [Vancomycin Resistant Enterococcus])..."	F 441		

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F 441	Continued From page 30 Observations March 7-9, 2011, from 9:00 a.m., through 4:00 p.m., revealed the resident was always lying in bed, dependent on staff, with a roommate who was independent in a wheelchair, and there was no sign to indicate the resident was in contact isolation. Interview with the Infection Control Practitioner on March 9, 2011, at 10:40 a.m., in the Unit Coordinator's office, confirmed residents with multi-drug resistant E. coli UTIs were to be placed in contact isolation. Further interview confirmed the resident had a multi-drug resistant E. coli UTI infection and had not been placed in contact isolation as indicated by the facility's policy. Resident #2 was admitted to the facility on December 27, 2010, with diagnoses including Sepsis, UTI (Urinary Tract Infection), Alzheimer's Dementia, and Parkinson's Disease. Medical record review of the Pressure Ulcer Status Record dated March 3, 2011, revealed the resident had a stage III pressure ulcer on the left ischium measuring 2 cm (centimeters) by 2 cm with a depth of 2/10 cm. Observation of a dressing change to the pressure ulcer on March 7, 2011, at 3:10 p.m., in the resident's room, with LPN (licensed practical nurse) #4, revealed the LPN, with gloved hands, removed the old dressing and placed it in a biohazard bag; without changing gloves or sanitizing the hands, irrigated the wound with a syringe full of normal saline; removed the gloves, and without sanitizing the hands, donned clean gloves and applied a clean dressing.	F 441		

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F 441	Continued From page 31 Review of the facility's policy Treatment of Pressure Sores, Chapter 3 (3-41 no date) revealed, "...5. Remove soiled dressing using no-touch technique and place in bag for disposal. Remove gloves and discard...6. Wash hands or use antiseptic hand cleanser...7. Apply new gloves 8. Cleanse wound as directed...9 Remove gloves and discard in disposable bag...10. Wash hands or use antiseptic hand cleanser...11. Apply new gloves and perform wound care as ordered..." Interview with LPN #4 on March 7, 2011, at 3:25 p.m., outside the resident's room, confirmed the LPN did not change gloves and sanitize the hands according to the facility's policy.	F 441		
F 502 SS=D	483.75(j)(1) PROVIDE/OBTAIN LABORATORY SVC-QUALITY/TIMELY The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to obtain a Urinalysis with Culture and Sensitivity for one (#11) of twenty-four residents reviewed. The findings included: Medical record review of the admission orders dated January 27, 2011, revealed an order to obtain a urinalysis each month. Medical record review of the Physician Telephone orders	F 502	**F 502 483.75(j)(1) PROVIDE/OBTAIN LABORATORY SVC-QUALITY/TIMELY** **SS= D** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident # 11 A urinalysis was obtained on resident on March 9th 2011 and results sent to MD. **Residents identified as having the potential to be affected by the same deficient practice. What corrective actions will be taken?** All residents have a potential to be affected. Residents with orders for a U/A since	4/12/2011

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F 502	Continued From page 32 revealed an order dated February 6, 2011, to obtain a UA & C/S (Urinalysis with Culture and Sensitivity). Review of the medical record revealed no results for the UA and C/S. Observation on March 7, 2011, at 10:15 a.m., revealed resident #11 lying supine in bed and a Foley catheter drainage collection bag containing yellow urine attached to the bed rail. Telephone interview on March 9, 2011, at 9:10 a.m., with the hospital laboratory department who performs the laboratory studies for the facility, revealed no UA was received from the facility for resident # 11. Interview with the Unit Manager of North Wing on March 9, 2011, at 9:11 a.m., confirmed the facility failed to obtain the Urinalysis with Culture and Sensitivity as ordered.	F 502	February 1st 2011 were audited to ensure all have been obtained and followed up on. The audits were conducted by the Unit Managers, DON, ADON and SDC and were completed by March 24th 2011. **What measures will be put into place or systematic changes will be made to ensure that the deficient practice does not reoccur.** Licensed Nursing staff were re-educated on process for obtaining U/A's when ordered and ensuring they are followed up on. The education was done by the DON, ADON, or SDC and was completed March 24th 2011 **How the corrective action(s) will be monitored to ensure the deficient practice will not reoccur?** DON, ADON, or Unit Managers are reviewing orders daily to ensure that any U/A order has been obtained and followed-up on. The findings of the audits will be taken to the Performance Improvement Committee by the ADON for the next three months beginning with the next meeting set for April 12th 2011.	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.	F 514	**F 514 483.75 (l) (1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE SS= D** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**	4/12/2011

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F 514	Continued From page 33 This REQUIREMENT is not met as evidenced by: Based on medical record review, review of the Pain Flow Sheet, review of the medication and controlled drug policies, observation, and interview, the facility failed to maintain accurate medical records for two residents (#7, #8) of twenty-four residents reviewed. The findings included: Resident #7 was admitted to the facility on March 23, 2010, and readmitted on June 4, 2010, with diagnoses including Muscle Weakness, Alzheimer's Disease and Right Humeral Head Fracture. Medical record review of the Minimum Data Set dated January 24, 2011, revealed the resident had short and long term memory problems totally dependent with two plus person physical assistance for bed mobility, transfer, toilet use and bathing. Further review revealed the resident indicated pain by non-verbal sounds, facial expressions and protective body movements. Further review revealed pain or possible pain was observed one to two days of the last five days in the review process. Medical record review of the physician phone order dated August 4, 2010, revealed "...Duragesic patch (pain medication) every 3 days for pain..." Medical record review of the September 2010, Recapitulation Orders, to the present revealed "...Fentanyl 25mcg/hr (micrograms per hour) patch (Duragesic) TD72 (Transdermal) apply and	F 514	Resident #7 On March 9th 2011 nursing giving direct care to resident received one on one re-education to ensure two nurses document narcotic patch destruction. Resident #8 On March 9th 2011 Licensed Nurse giving care to resident received one on one re-education to ensure that narcotics given are signed out on front of MAR, back of MAR and on controlled substance sheet. **Residents identified as having the potential to be affected by the same deficient practice. What corrective actions will be taken?** All residents receiving a controlled substance have a potential to be affected. Residents currently having a narcotic medication patch MAR /controlled substance record were audited to ensure policy for narcotic patch destruction was being followed. Resident currently on a controlled substances MAR/ controlled substance records were monitored to ensure number of times given matches. **What measures will be put into place or systematic changes will be made to ensure that the deficient practice does not reoccur.** Licensed Nurses were re-educated on Policy for control substance documentation and destruction of controlled substances patches. The education was given by the SDC, DON, or ADON. The education was completed on March 24th 2011. **How the corrective action(s) will be monitored to ensure the deficient practice will not reoccur?**	

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F 514	Continued From page 34 remove 1 patch every 72 hours..." Continued review revealed the order for "...Upon removal of Duragesic patch, destroy it. Two nurses to document..." Review of the Medication Administration Records for the removal of the patch with two nurses to document revealed the following: August 2010: there was no documentation by two nurses on August 8, 14, 17, 24, 27, 30. September 2010: documentation of removal of the patch daily except for September 19 and 30 indicated by one or two signatures. October 2010: the entire month had no signatures. November 2010: there was no documentation by two nurses on November 18 and 27. December 2010: there was no documentation by two nurses on December 12 and 30. January 2011: there was no documentation by two nurses on January 10, 13, 19, 22, 25, 28, and 31. February 2011: there was no documentation by two nurses on February 3, 6, 12, 21, and 27. Interview, with the Director of Nursing on March 8, 2011, at 2:00 p.m., by the 100 nursing station, and the Regional Nurse on March 9, 2011, at 9:00 a.m., in the dining room, confirmed the facility failed to have two nurses document the Fentanyl patch removal as ordered and confirmed the the medical record was incomplete. Resident #8 was admitted to the facility on March 9, 2009, and readmitted on November 24, 2010, with diagnoses including Anxiety, Depression, Psychosis, Chronic Kidney Disease, Muscle Spasm, Nuclear Sclerosis, Degeneration of	F 514	Unit Managers, DON, ADON, SDC will monitor control substance records once a week to ensure that the number of times given matches on the MAR front and back and on the Narcotic Control Substance sheet, and narcotics are wasted per facility policy. Findings of audits will be taken to the Performance Improvement Committee by the ADON for the next 3 months beginning with the next meeting set for April 12th 2011.	

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F 514	Continued From page 35 Lumbar/Lumbarsacral Intervertebral Disc and Obesity. Medical record review of the Minimum Data Set dated November 30, 2010, revealed the resident was 15 out of 15 for cognitive skills, with 15 being the highest level; required limited assistance with one person physical assistance for bed mobility, transfer, ambulation, dressing, toilet use, and bathing. Continued review revealed the resident had received scheduled and as needed (PRN) pain medication and non-medical intervention for pain. Continued review revealed the resident experienced pain "frequently" with a 5 out of 10 intensity, with zero being no pain and ten the worst pain imagined. Medical record review of the physician phone order dated February 21, 2011, revealed "...Endocet (pain medication) 10/325 mg (milligrams) po Q 4 h PRN (by mouth every 4 hours as needed) (pain)..." Medical record review of the March 2011, Medication Administration Record (MAR) revealed the Endocet (Percocet) 10/325 mg po Q 4 h PRN was administered as follows: March 2 and 3, one time each; March 4, two times; March 5, none; and on March 7, three times. The back of the MAR revealed the Endocet was documented as provided for back pain as follows: March 2 and 3, two times each; March 4, one time; March 5, had no documentation and on March 7, two times. Medical record review of the March 2011, Controlled Substance Record for "...Oxycod-Acetamin (Endocet/Percocet) 10/325 one tablet every 4 hours as needed for pain ."	F 514		

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F 514	Continued From page 36 revealed removal of the medication from supply as follows: March 2, four times; March 3, two times; March 4, three times; March 5, one time; and March 7, four times. Further review revealed ten pills remained to be dispensed as of March 9, 2011, at 8:45 a.m. Review of the March 2011, Pain Flow Sheet revealed Endocet/Percocet was provided for pain as follows: March 2 and 3, no documentation; March 4, one time; March 5, no documentation; March 6, one time; and on March 7, no documentation. Review of the Policies for Medication Administration revealed "...Procedure...13. Initial each medication in the correct box on the MAR after the medication is given...17. PRN medication is charted with initials, and time is given in the corner of the box. The following situations require an accompanying note: c. Pain..." Review of the policy for Controlled Drugs revealed "...Procedure 4. The nurse signs off each dose of the controlled drugs given by documenting: a. Date...b. Hour...c. Resident name...d. Physician...e. Amount dispensed...f. Signature of nurse...g. Balance after subtracting amount dispensed..." Observation on March 9, 2011, at 8:45 a.m., of the Endocet drug packet revealed ten pills remained. Interview with Licensed Practical Nurse #5 confirmed the MAR administration documentation did not coincide with the back of the MAR explaining the reason for the administration	F 514		

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F 514	Continued From page 37 Further interview confirmed the MAR did not match the Controlled Substance Record or the Pain Flow Sheet and confirmed the medical record was inaccurate/incomplete.	F 514		